CONFIDENTIAL

TRANSMISSION VERIFICATION REPORT

TIME : 07/20/2015 17:08
NAME : BMH DESOTO
FAX : 662-772-2180
TEL :
SER.# : L7J563231

DATE,TIME	07/20 17:07
FAX NO./NAME	914045627478-7009171
DURATION	00:00:47
PAGE(S)	03
RESULT	OK
MODE	STANDARD ECM

Called. Instructions or answers regarding that needed to fax report only. JF

Baptist Memorial Hospital Desoto

Address: 7601 Southcrest Pkwy, Southaven, MS 38672
City, State, and Zip Code: _____

Facsimile Cover Sheet

Date: 7/20/15 # of pages including cover sheet: 3

To:	From:
Joe Ann Hollingsworth	Janet Tidwell
CMS-Region IV	Risk Manager
Phone:	Phone: 662-772-2356
Fax Phone #: 404-562-7478	Fax Phone #:
Copy:	E-mail:

Remarks: ☐ Urgent ☒ For your review ☐ As requested ☐ Reply ASAP ☐ Please Comment

Re: Hospital Restraint Worksheet

Form 0100.22 11/09

CONFIDENTIAL

HOSPITAL RESTRAINT/SECLUSION DEATH REPORT WORKSHEET

(Revised 7/08)

A. Regional Office (RO) Contact Information:

RO Contact's Name: Joe Ann Hollingsworth

*Date of Report to RO: 7/20/2015 Time: 1630

B. Provider Information:

*Hospital Name: Baptist Memorial Hospital Desoto *CCN: 250141

Address: 7601 Southcrest Parkway City: Southaven State: Mississippi Zip Code: 38671

Person Filing the Report: Janet Tidwell Filer's Phone Number: 662-772-2356

C. Patient Information:

*Name: Troy Goode *Date of Birth: [redacted]

*Admitting Diagnoses: Drug abuse, acute psychosis

*Date of Admission: 7/18/2015

*Date of Death: 7/18/2015 *Time of Death: 2144

*Cause of Death: Cardiopulmonary arrest

*Did the Patient Die: *(check one only)*

__X__ While in Restraint, Seclusion, or Both

_____ Within 24 Hours of Removal of Restraint, Seclusion, or Both

_____ Within 1 Week, Where Restraint, Seclusion or Both Contributed to the Patient's Death

*Type: Physical Restraint _____ Seclusion _____ Drug Used as a Restraint __X__

***Was a Two Point Soft Wrist Restraint used alone, without seclusion or chemical restraint or any other type of physical restraint? Yes ____ No __X__**

If YES, check "02" below and stop. No further information is required.

If NO, complete the rest of the worksheet.

*If Physical Restraint(s), Type:

_____01 Side Rails	_____08 Take-downs
_____02 Two Point, Soft Wrist	_____09 Other Physical Holds
_____03 Two Point, Hard Wrist	_____10 Enclosed Beds
_____04 Four Point, Soft Restraints	_____11 Vest Restraints
_____05 Four Point, Hard Restraints	_____12 Elbow Immobilizers
_____06 Forced Medication Holds	__X__13 Law Enforcement Restraints
_____07 Therapeutic Holds	_____14 Other Physical Holds

If Drug Used as Restraint: *Drug Name Haldol Dosage 5mg IV

Drug Name Ativan Dosage 2mg IV

****Mandatory field***

CONFIDENTIAL

D. Hospital-Reported Restraint/Seclusion Information:

*1. Reason(s) for Restraint/Seclusion use: *(mandatory only if answer to D.4. is "yes")*

Patient attempting to harm self

2. Circumstances Surrounding the Death:

Called to room, Southaven Police Department officers at bedside, for possible respiratory arrest. Patient in full arrest. Resuscitation efforts begun. Resuscitation unsuccessful

3. Restraint/Seclusion Order Details:

a. Date & Time Restraint/Seclusion Applied: Haldol and Ativan given on 7/18/15 at 2108

b. Date & Time Last Monitored: Patient being constantly monitored

*c. Total Length of Time in Restraint/Seclusion: 36 minutes

*4. Was restraint/seclusion used to manage violent or self-destructive behavior? Yes_X_ No___

*a. *If YES, was 1 hour face-to-face evaluation documented? Yes*_X_ *No*___

If NO, skip to Section E.

*b. Date/Time of Last Face-to-face Evaluation: 7/18/2015 at 2107

*c. Was the order renewed at appropriate intervals based on patient's age? Yes_ No_ NA X

Note: Orders may be renewed at the following intervals for up to 24 hours:

> 18 years of age	*every 4 hours*
9 – 17 years of age	*every 2 hours*
< 9 years of age	*every hour*

Not applicable—patient expired before renewal due

*5. If simultaneous restraint and seclusion ordered, describe continuous monitoring method(s):
Did not seclude patient

E. RO Action(s):

1. *Was a survey authorized? Yes____ No____

If YES, date SA received authorization for investigation: _____

If NO, provide brief rationale: _____

2. *If answer to E1 is yes, date RO contacted P & A: _____

(Do not contact the P&A unless a survey was authorized)

3. In the past two years, has a survey related to a restraint/seclusion death at this hospital resulted in finding condition-level patients' rights deficiencies? Yes____ No____

Mandatory field